Department of Medical Assistance Services
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http://www.dmas.state.va.us

MEDICAID MEMO

TO: All Substance Use Disorder Providers, Managed Care Organizations (MCOs) and Magellan of Virginia Participating in the Virginia Medical Assistance Program

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 10/12/17

SUBJECT: Clarification on Residential Levels of Care in the Addiction and Recovery Treatment Service (ARTS) Benefit

On April 1, 2017, the Department of Medical Assistance Services (DMAS) launched an enhanced substance use disorder treatment benefit - **Addiction and Recovery Treatment Services (ARTS).** The ARTS benefit provides treatment for those with substance use disorders across the state. The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid, FAMIS, FAMIS MOMS and the Governor's Access Plan (GAP) including expanded community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential substance use disorder treatment.

Prior to the implementation of ARTS, DMAS applied for and was approved by the Centers for Medicare and Medicaid Services (CMS) for a 1115 Demonstration Waiver. The waiver allowed DMAS to avoid the federal limitation of not funding residential facilities that meet the federal definition of an Institution for Mental Disease (IMD) under the ARTS benefit for members between the ages of 21 and 64. The State Medicaid Manual, published by CMS, defines an IMD as "…a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." Thus, with the ARTS Waiver, **CMS is allowing DMAS to cover short term residential services in facilities that meet the definition of an IMD for the treatment of substance use disorders and withdrawal management.** However, with the approval of the waiver, **CMS has several requirements** for DMAS to meet in order to continue **to receive federal funding for the payment of substance use disorder treatment services in these IMD settings.**

The purpose of this memorandum is to share with providers the CMS requirements that DMAS must meet for the ARTS residential benefit, specifically the American Society of Addiction Medicine (ASAM) Levels 3.1, 3.3, 3.5 and 3.7.

Residential Services Length of Stay

CMS requires that any member receiving residential substance use disorder services pursuant to the ARTS demonstration, regardless of the length of stay or the bed size of the facility, be a "short-term resident" of the residential or inpatient facility in which they are receiving the services. **Short-term residential treatment is defined as a statewide average length of stay of 30 days.** CMS further stated residential treatment services should be provided **as medically necessary as determined by an independent party consistent with the ASAM**

assessment, detailed in the "Service Authorization for Residential Services" section in this memorandum. CMS requires DMAS to track and report members who are receiving residential levels of care. DMAS will utilize weighted averages to take into consideration those members with higher levels of need, such as members who are pregnant and receiving residential levels of care. As of September 22, 2017, CMS removed the maximum limit of days in residential or inpatient facilities including any individual admitted into a facility who is certified as meeting ASAM Level 3.1, 3.3, 3.5 or 3.7, as long as DMAS meets the statewide 30-day average lengths of stay. Thus is it **imperative that providers begin planning and preparing with the member for the transition from the current level of care to other appropriate levels of care** when the member no longer requires the current level of care based on ASAM Criteria *3rd Edition*.

Discharge Planning

Since CMS requires "short term" residential stays, providers **shall begin planning for the member's discharge at time of their admission**. Thus, all comprehensive individual service plans (ISPs) for residential levels of care shall include an individualized discharge plan to the most appropriate ASAM Level of Care based on the multidimensional assessment. Anticipated discharge plans are documented at the start of treatment. The discharge plan describes the discharge planning activities, summarizes an estimated timetable to achieving the goals and objectives in the service plan, and includes discharge plans that are kept current and specific to the needs of the member. The discharge plan shall address the plan for transitioning from an appropriate residential ASAM Levels of Care to a lower ASAM Levels of Care.

Service Authorization for Residential Services

CMS requires an independent third party to review all requests for residential levels of care to determine if members meet medical necessity based on ASAM Criteria *3rd Edition*. CMS requires DMAS to contract with each of the managed care organizations (MCOs) and Magellan of Virginia for ARTS Care Coordinators[1], physician reviewers and medical directors to perform these independent reviews. Practitioners reviewing these service authorization requests **must determine the appropriate level of care and length of stay recommendations based upon the ASAM Criteria** *3rd Edition* **and the multidimensional assessment** to match severity and level of function with type and intensity of service for adults and adolescents. DMAS requires the ARTS Care Coordinators, physician reviewers or medical directors to document the use of the **ASAM multidimensional assessment and matrices for matching severity with type and intensity of services** based on the ARTS Uniform Service Authorization form.

ASAM specifies that once admission for a given level of care has met the Criteria, there are specific requirements for continued service, discharge or transfer from that particular level of care. Providers, MCOs and Magellan of Virginia shall apply the ASAM Criteria as specified below:

<u>Continued Service Criteria</u>: It is appropriate to retain the member at the present level of care if:

1. The member is making progress, but has not yet achieved the goals articulated in the individualized service plan. Continued treatment at the present level of care is assessed as necessary to permit the member to continue to work towards treatment goals; or

[1] ARTS Care Coordinators are as follows: licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, nurse practitioners, or registered nurses with substance use disorder experience and the necessary competencies to use the ASAM multidimensional assessment criteria and matrices, to match severity and level of function with type and intensity of service for adults and adolescents.

2. The member is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working on the goals articulated in the individualized service plan. Continued treatment at the present level of care is assessed as medically necessary to permit the member to continue to work toward his or her treatment goals; and/or

3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the member's new problems can be addressed effectively.

The provider shall document and communicate the member's readiness for discharge or need for transfer to another level of care **based on each of the six dimensions of the ASAM Multidimensional Assessment**. If the assessment reflects that the member's problems continue to exist or new problem(s) are identified in the residential level of care, the member should continue in treatment at the present level of care. If not, the member shall be discharged/transferred to another ASAM Level of Care as indicated below.

Discharge/Transfer Criteria: It is appropriate to transfer or discharge the member from the present level of care if he or she meets the following criteria:

1. The member has achieved the goals articulated in the individualized service plan, thus resolving the problem(s) that justified admission to the current level of care; or

2. The member has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the individual service plan. Treatment at another level of care or type of service therefore is indicated; or

3. The member has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated; or

4. The member has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

Managed Care and ASAM

The ASAM Criteria *3rd Edition* provide principles on how to work effectively in a managed care environment (beginning on page 119 of the ASAM Criteria). ASAM states that all practitioners as well as managed care organizations are responsible for "managing care" and utilizing resources appropriately. ASAM Criteria provides the following guidance for working with managed care:

- Clinical assessments by the treatment team shall encompass factual, biopsychosocial data;
- A case presentation format can be used to document the biopsychosocial data following the multidimensional assessment (same format in ASAM Criteria page 125);
- Use the decisional flow process to match the assessment and treatment/placement assignment to guide the clinical discussion (ASAM Criteria page 124);
- If the provider and the ARTS Coordinator/Physician disagree with the treatment/placement discussion, identify the specific area of disagreement; and
- If no agreement is reached, providers may utilize the managed care/Magellan of Virginia appeal process that will be documented in the authorization denial.

Patient Utilization and Safety Management Program (PUMS)
All contracted Medicaid MCOs including Medallion 3.0 and Commonwealth Coordinated Care Plus (CCC Plus) are required to have a Patient Utilization & Safety Management Program (PUMS). Note: Neither the CCC plans (Medicare/Medicaid Plans) nor Magellan of Virginia have the PUMS requirements. The PUMS program is intended to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and case management program designed to promote proper medical management of essential health care. Upon the member's placement in the PUMS, the MCO must refer members to appropriate services based upon the member's unique situation and service needs. Medical providers or social service agencies such as Department of Social Services or Community Service Boards may provide direct referrals to the Department or the Medicaid managed care health plan (MCO).

Placement into a PUMS Program
Members may be placed into a PUMS program for a period of twelve (12) months when either of the following trigger events occurs:

- **(PUMS1) Buprenorphine Containing Product***: Therapy in the past thirty (30) days – **AUTOMATIC LOCK-IN**
  *If on monoproduct (indicating pregnancy), refer to case management.
  **Exclude members using Butrans and Belbuca only when used for the treatment of pain.

- **(PUMS2) High Average Daily Dose**: ≥ one hundred and twenty (120) cumulative morphine milligram equivalents (MME) per day over the past ninety (90) days.

- **(PUMS3) Opioids and Benzodiazepines concurrent use** – at least one (1) Opioid claim and fourteen (14) day supply of Benzo (in any order).

- **(PUMS4) Doctor and/or Pharmacy Shopping**: ≥ three (3) prescribers OR ≥ three (3) pharmacies writing/filling claims for any controlled substance in the past sixty (60) days.

- **(PUMS5) Use of a Controlled Substance with a History of Dependence, Abuse, or Poisoning/Overdose**: Any use of a controlled substance in the past sixty (60) days with at least two (2) occurrences of a medical claim for controlled Substance Abuse or Dependence in the past three hundred and sixty-five (365) days.

- **(PUMS6) History of Substance Use, Abuse or Dependence or Poisoning/Overdose**: Any member with a diagnosis of substance use, substance abuse, or substance dependence on any new* claim in any setting (e.g., ED, pharmacy, inpatient, outpatient, etc.) within the past sixty (60) days.

PUMS Program Details
Once a member meets the placement requirements, the MCO may limit a member to a single pharmacy, primary care provider, controlled substances prescriber, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types as determined by the MCO and the circumstances of the member. The MCO shall limit a member to providers and pharmacies that are credentialed in their network.

PUMS1 Lock-In Process Requirements

Members identified for placement in PUMS1 shall be automatically locked-in to an in-network Buprenorphine waivered prescriber. The MCO shall review automatic lock-ins and transition members to a Preferred Office Based Opioid Treatment (OBOT) practice when available. The MCO shall lock-in the member to all MCO credentialed Buprenorphine waivered prescribers associated with the OBOT practice.

If members are referred to an **ARTS Residential Treatment Facility, and need to continue medication management, the Residential provider shall contact the MCO to request the prescriber/pharmacy be updated to one that the Residential provider utilizes**, so that the member may continue the current medical regimen. Provider may contact the health plans and Magellan of Virginia to update the preferred prescriber/pharmacy while member is in the residential treatment program. The health plan contacts are attached to the memorandum. Upon discharge from the Residential Treatment Facility, the provider shall notify the member's MCO of the discharge so that the member's prescriber/pharmacy provider can be updated based on the member's choice and proximity to their place of discharge. This task shall be included on the discharge planning process.

Buprenorphine Prescriptions

Medicaid health plans have the contractual authority to deny coverage of buprenorphine prescribed by out-of-network providers and will not pay for buprenorphine prescribed by out-of-network providers beginning November 1, 2017. In-network providers will be exempt from the service authorization requirement for the first 7 days during induction however will require service authorizations after the initial 7 days. Providers who are **approved and credentialed** with the MCOs and Magellan of Virginia as a **Preferred OBOT** provider and/or a **Preferred Residential Treatment Provider** as detailed below are **exempt from service authorization requirements for buprenorphine products**. If the Residential provider is not approved as a "Preferred Residential Treatment Provider" they may collaborate with an approved OBOT provider or an in-network buprenorphine waivered provider. A list of DMAS approved and credentialed Preferred OBOT providers are located: http://www.dmas.virginia.gov/Content_pgs/bh-home.aspx.

New Preferred Medication Assisted Treatment Providers

Residential treatment providers, along with Intensive Outpatient and Partial Hospitalization providers, who are providing Medication Assisted Treatment (MAT) and who are currently credentialed with a Medicaid Managed Care Organization or Magellan of Virginia as an ARTS provider can apply to be a "**Preferred Medication Assisted Treatment Provider**". The Preferred MAT status will allow the buprenorphine waivered practitioner of the facility to prescribe buprenorphine related products to be filled at local pharmacy and be exempt from the service authorization process. The Preferred Medication Assisted Treatment attestation packet is located online at: http://www.dmas.virginia.gov/Content_pgs/bh-cred.aspx.

Providers should complete these forms and send to **DMAS at fax: 804-452-5450** for the physician team to review for decision. If DMAS approves the application, DMAS will notify the MCOs and Magellan of Virginia. Providers will still need to complete the credentialing process with each MCO and Magellan of Virginia to ensure that the buprenorphine waivered practitioners are credentialed to be reimbursed for the professional services and waive the buprenorphine service authorization.

Initial Rate Setting Process for New Residential Treatment Facilities ASAM Level 3.3/3.5/3.7
All new Residential Treatment Facilities or providers adding on a new ASAM Level of Care for Residential Services (ASAM Level 3.3, 3.5 or 3.7) are required to file a pro-forma cost report for the determination of the initial rate. Allowable costs for reimbursement purposes are determined in accordance with Medicare Principles of Reimbursement, including the rules set forth in the Provider Reimbursement Manual, (CMS Pub 15-1). Allowable costs for determining the Residential Treatment Facility Rate do not include costs for drugs and professional (physician) services or primary/secondary/post-secondary education costs. The Residential Treatment Facility Rate cannot exceed $393.50 per day. Drugs and professional services must be billed directly to the MCO or Magellan of Virginia (professional services) / Magellan Health Services (pharmacy), depending on the member's benefit.

A copy of the pro-forma cost reporting form RTF-608 can be found on the Medicaid Web Provider Portal at https://www.virginiamedicaid.dmas.virginia.gov under "Provider Services" and "Provider Forms Search" section. Complete the RTF – 608 Cost Reporting Form in accordance with the following instructions and submit with additional documentation per Attachment A – Submission Instructions. The completed cost report with additional information as described in the instructions should be submitted to the DMAS cost settlement and auditing contractor.

Additional information about the ARTS program can be found at http://www.dmas.virginia.gov/Content_pgs/bh-home.aspx.

ASAM Level and Licensing Crosswalk for Residential Settings
DBHDS Office of Licensing developed a crosswalk for residential provides that aligned the various DBHDS licenses by ASAM Level of Care. DMAS is notifying providers that they must meet the ASAM Criteria for the appropriate level of care, and providers must also be licensed appropriately based on the ASAM Level of Care and Licensing Crosswalk below:

ASAM Level of Care	ASAM Description	DBHDS Licenses	DBHDS License Numbers
3.7	Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)	Freestanding Psychiatric Hospital and Inpatient Psychiatric Unit with a DBHDS Medical Detoxification License or Managed Withdrawal License;	04-001 thru 004 (adults); 04-005 (children); 04-011 thru 012 (medical detox); or 01-025 thru 026 (managed withdrawal)
		Substance Abuse Residential Treatment Services (RTS) for adults/children with a DBHDS Managed Withdrawal License;	01-006 (adults); 14-007(children); or 01-025 thru 026 (managed withdrawal)
		Residential Crisis Stabilization Unit with a DBHDS Medical Detoxification License or Managed Withdrawal License;	01-019 (adults); 01-020 (children); 04-011 thru 012 (medical detox); or 01-025 thru 026 (managed withdrawal)

		Substance Abuse Residential Treatment Services (RTS) for Women with Children with a DBHDS Managed Withdrawal License;	01-033 thru 034 (Women); or 01-025 thru 026 (managed withdrawal)
		Level C or Mental Health Residential Children with a substance abuse residential license and a DBHDS Managed Withdrawal License;	14-001 thru 003 w/ SA in licensed as description; 14-004 thru 006; 14-054 thru 058 w/SA in licensed as description; or 01-025 thru 026 (managed withdrawal)
		Managed Withdrawal-Medical Detox Adult Residential Treatment Service (RTS) License; or	01-025 thru 026
		Medical Detox/Chemical Dependency Unit for Adults.	04-011 thru 012 (medical detox)
3.5	Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent)	Substance Abuse Residential Treatment Services (RTS) for Adults or Children;	01-006 (Adults); or 14-007 (Child)
		Psychiatric Unit that have substance abuse on their license or within the "licensed as statements";	04-001 thru 004 (adults); or 04-005 (children)
		Substance Abuse RTS for Women with Children;	01-033 thru 034 (Women)
		Substance Abuse and Mental Health Residential Treatment Services (RTS) for Adults that have substance abuse on their license or within the "licensed as statements."; or	01-006 (Adults)
		Level C or Mental Health Residential Children that have substance abuse on their license or within the "licensed as statements".	14-001 thru 006 (only with SA in license description); or 014-007 (only with SA in license description)
		If providers are providing withdrawal management, they will need to also have a DBHDS Medical Detox license.	04-011 thru 012 (medical detox); or 01-025 thru 026 (managed withdrawal)
3.3	Clinically Managed Population-Specific High-Intensity Residential Services (Adults)	Substance Abuse Residential Treatment Services (RTS) for Adults;	01-006
		Substance Abuse Residential Treatment Services (RTS) for Women with Children;	01-033 thru 034 (Women)

		Substance Abuse and Mental Health Residential Treatment Services (RTS) for Adults that have substance abuse on their license or within the "licensed as statements." or	01-006
		Level C or Mental Health Residential Children that have substance abuse on their license or within the "licensed as statements."	14-001 thru 006 (only with SA in license description); or 14-007 (only with SA in license description)
		If providers are providing withdrawal management, they will need to also have a DBHDS Medical Detox license.	04-011 (medical detox – adults)
3.1	Clinically Managed Low-Intensity Residential Services	Mental Health & Substance Abuse Group Home Service for Adults or Children; or	01-003 (Adults) (only with SA in license description; 14-033 (Children); or 14-034 (Children
		Supervised Living Services for Adults.	01-013
		Note: DBHDS is no longer issuing the Substance Abuse Halfway House for Adults licenses. Providers who need to update their licenses should contact their licensing specialist with DBHDS for further guidance.	

DMAS has contracted with a third party vendor to perform site visits of residential treatment providers to perform an assessment and certify whether the provider meets the particular ASAM Criteria for that level of care. The ASAM certification is required for the provider to be credentialed with the Medicaid MCOs and Magellan of Virginia in addition to meeting the licensing requirements.

Attachment 1: PUMS Lock-In Point-of-Contact

MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)

Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

MANAGED CARE PROGRAMS

Most Medicaid individuals are enrolled in one of the Department's managed care programs: Medallion 3.0, Commonwealth Coordinated Care (CCC), Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may

utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

- Medallion 3.0: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Commonwealth Coordinated Care (CCC): http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
- Commonwealth Coordinated Care Plus (CCC Plus): http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
- Program of All-Inclusive Care for the Elderly (PACE): http://www.dmas.virginia.gov/Content_atchs/ltc/WEB%20PAGE%20FOR%20PACE%20Sites%20in%20VA.pdf

COMMONWEALTH COORDINATED CARE PLUS

Commonwealth Coordinated Care Plus is a required managed long term services and supports program for individuals who are either 65 or older or meet eligibility requirements due to a disability. The program integrates medical, behavioral health, and long term services and supports into one program and provides care coordination for members. The goal of this coordinated delivery system is to improve access, quality and efficiency. Please visit the website at: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE

There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is http://www.dmas.virginia.gov/Content_pgs/appeal-home.aspx and the form can be accessed from there by clicking on, "Click here to download a Provider Appeal Request Form." The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed

to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

PROVIDERS: NEW MEDICARE CARDS ARE COMING

CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, CMS has stated that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, CMS has referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, CMS will refer to this project as the New Medicare Card.

To help you find information quickly, CMS designed a new homepage linking you to the latest details, including how to talk to your Medicare patients about the new Medicare Card. Bookmark the New Medicare Card homepage and Provider webpage, and visit often, so you have the information you need to be ready by April 1.

Providers (which includes fee for service, Medicaid Managed Care Organizations, and Commonwealth Coordinated Care Plus) may share the following information with members:

MEMBERS: NEW MEDICARE CARDS ARE COMING

Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare Number that's unique to you, instead of your Social Security Number. This will help to protect your identity.

Additional information is available at the following link:
https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html

PUMS Lock-In Point of Contact

Health Plan	Contact
Aetna Better Health & Aetna Better Health of Virginia	Robert Coalson, Pharm. D, MBA Aetna Better Health of Virginia (717) 673-2113 (w) rlcoalson@aetna.com
Anthem HealthKeepers Plus	Linda Worley 1-844-533-1994 Ext. 48360 linda.worley@anthem.com
INTotal Health	Kristi Fowler, R. Ph. Director Managed Pharmacy Services INTotal Health (202) 681-8046 Kristi.Fowler@inova.org
Kaiser Permanente	Pharmacy Benefit Team (703) 466-4800, Option 1 MAS-PHARM-BENEFITS@kp.org Anila Xhixho, PharmD., CDE Pharmacy Benefit Specialist (703)466-4800, Option 1 Anila.K.Xhixho@kp.org
Magellan Complete Care of Virginia	**Gabrielle Williams, PharmD, MBA** Pharmacy Services Manager (804) 461-9475 GWilliams5@magellanhealth.com
Optima Family Care	(800) 648-8420 (757) 552-7174
Optima Health Community Care	(888) 946-1168
Virginia Premier Health Plan & Virginia Premier Complete Care	Javier Menendez, R.Ph. Pharmacy Director 800-727-7536 Ext. 55269 Javier.Menendez@vapremier.com Emily Allen, 800-727-7536 Ext. 55367 Emily.Allen@vapremier.com Pharmacy Hunt Group (anyone can assist) 800-727-7536 Ext.77121